BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.1
DATE: April 13, 2011

ACTION REQUESTED: Information only: "Nothing Left Behind" speaker Gayle Sarlatte, RN, CNOR

REQUESTED BY: Judy L. Corless, BSN, RN, Chairperson Nursing Practice Committee

BACKGROUND:
At the January 5, 2011 Practice Committee meeting at the public comment for items not on the agenda a representative of Operating Room Nursing Council suggested the committee be made aware of the new AORN 2010 Recommended Practice for Retained Surgical Items. Also of interest is "Nothing Left Behind" a National Surgical Patient-Safety Project to prevent retained surgical items sponsored by a physician at University California San Francisco.

The committee liaison was contacted by the Operating Room Nursing Council who proposed two members who would present information on current safety issues and cutting edge technology related patient safety in the operating environment.

Nothing Left Behind A National Surgical Patient-Safety Project to Prevent Retained Surgical Items, Verna C Gibbs M.D. Director, Nothing Left Behind, Professor Clinical Surgery UCSF, Staff Surgeon, SFVAMC.

Perioperative Standards and Recommended Practices (July 2010). Recommended practice for sponge, sharp, and instrument counts providing guidance to perioperative registered nurses in preventing retained surgical items in patients undergoing surgical and other invasive procedures. www.aorn.org/psrp

NEXT STEPS: Board

FISCAL IMPLICATIONS, IF ANY: None

PERSON(S) TO CONTACT: Janette Wackerly, MBA, RN
Nursing Education Consultant
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Gayle Sarlatte, RN, CNOR

March 10, 2011

Drill bits, screws, sponges, clamps, needles, catheters, electrodes—these are some of the items inadvertently left inside patients under-going surgical and invasive procedures in CA. Retained foreign items account for the second most common preventable adverse event in acute care. In 2001, the Institute of Medicine (IOM) identified as one of six goals to achieve a better health care system *avoiding injuries from the care that is intended to help patients.* Behavioral change and a clear understanding of risk reduction strategies unique to each patient care setting is needed. Medicare has a policy to no longer pay an additional amount for treatment associated with retained surgical items (RSI). Commercial insurance companies have followed suit.

In 2006, SB 1301, Chapter 647 was enacted to mandate hospitals to report adverse events to the CA Department of Public Health (CDPH) within specified timeframes and imposed penalties to hospitals for failure to report said adverse events in a timely manner. In 2008, SB 541, Chapter 605 increased the administrative penalties assessed against hospitals. Funds were deposited into a Special Deposit Fund under Section 16370 of the Government Code.

Adverse events run the gamut:

- Improperly assessing newborns at risk for hyperbilirubinemia
- Fire in C-section operating room caused by incorrect humidity levels.
- Wrong site surgery
- Retained surgical item(s) requiring re-operation

and the list goes on.

Following passage of SB 1301, a reporting mechanism was implemented which leads up to a competency investigation of the Registered Nurse. Today's testimony will be focusing on the Registered Nurse circulator and procedural counts. The reporting sequence is as follows:

- Foreign object is retained
- Sentinel event is reported to JCAHO
- CA Public Health Department is notified at the same time as JCAHO
- CA Public Health Department notifies the BRN
- CA Public Health Department directs their RN investigative staff to begin an investigation
- If criteria is met—e.g.return to surgery—the BRN goes forward with a competency investigation which includes the Registered Nurse circulator, the Perioperative Nurse Manager and the Perioperative Director/VP

What the Operating Room Nursing Council of California (ORNCC) is requesting of the BRN Practice Committee is a re-assessment of the investigative process when retained foreign items are reported to them.

As practice arenas where counts are required change and expand—e.g. Interventional Radiology, L & D, OR/Ambulatory Care Surgery (ACS)/Office practice—the establishment of a collaborative as a quality improvement process is occurring in many hospitals. By collaborative we mean developing a process to focus on a single adverse event (counts) in order to implement best practices related to the same event in multiple settings.

Patient safety issues have prompted retrospective studies of retained foreign items and indentified several risk factors as a root cause:

- Emergency surgery
- Unexpected changes in the operative procedure
- High patient body mass index (BMI)
- Not following procedures
- Communication failures
- Distraction from multiple competing interests
- Pressure for increased productivity
- Lack of sufficient personnel

Retrospective studies in turn prompted the Perioperative nursing community to look at count methodology, present policies/procedures and new products on the market. Technology is starting to take its place as a supplement to manual counts in an effort to prevent RSI's. Understand the ORNCC is not here advocating any product over another. The ORNCC is here to bring awareness to the changes in this patient safety issue and the movement within Perioperative nursing practice to see counts as a multidisciplinary function of patient care in the surgical arena including nursing, medicine and administration.

The Association of PeriOperative Nursing (AORN) in 2010 presented their *Recommended Practice for the Prevention of Retained Surgical Items.* Recommendation I states:

A consistent multidisciplinary approach for preventing retained surgical items (RSI) should be used during all surgical and invasive procedures. This includes soft goods, sharps and instruments.

Verna C. Gibbs, MD, professor of clinical surgery at University California San Francisco is spearheading a national patient safety project to prevent RSI's called *NoThing Left Behind.* Catholic Healthcare West (CHW) is presently piloting the project in their forty-one (41) facilities in CA. Both of these counting procedures require a multidisciplinary approach to RSI's to be carried out in operative and invasive procedures

In 2008 the pilot study for what is now known as the World Health Organization Surgical Safety Checklist was initiated. In January 2009 the New England Journal of Medicine published the results of the pilot which had demonstrated substantial reduction in complications and mistakes during the surgical event. In seven of the eight hospitals around the world that had participated in the pilot study, there was a double digit drop in errors.

Atul Gawande, a general and endocrine surgeon at the Brigham and Women's Hospital, also leads the WHO Safe Surgery Saves Lives program. He recognized that the complexity of the surgical environment and the fallibility of the human memory and attention when it comes to routine matters that can be easily overlooked under the strain of more pressing events. He studied the most successful use of checklists to save lives, that of the aviation industry.

As a result of Dr. Gawande and his WHO team they compiled the Surgical Safety Checklist which addresses the complexity of modern medicine and identifies the need to depend on systems which is an assembly of people and technologies. The difficulty is making them work together. Just as the airline pilot and the co-pilot rely on one another to communicate and check for safety, so does the entire surgical team rely on one another to provide safe patient care.

The checklist, when used properly, has been developed as a tool to aid the entire team to work together, communicate openly and freely and to provide the safest environment for the patient. They recognized the failures occurred over and over even by those of great ability, competentency, and

determination. It was time to try another method, the checklist of aviation to assist everyone on the surgical team.

The ORNCC is in total support of the multidisciplinary approach to RSI's and is asking the Practice Committee to consider implementing the same approach when investigating the Registered Nurse involved in retained surgical items. The ORNCC also believes the adoption of a checklist approach to investigative procedures regarding counts would be beneficial to all those involved.

Thank you.

OR Manager Inc

OR Manager
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Patient safety

Preventing retained items: Time to consider technology?

Technology is starting to take its place as a supplement to manual counts in the effort to prevent retained surgical items (RSIs). RSIs persist despite the emphasis many ORs have placed on tightening their manual counting methods. Recent reports from California are an example of the challenge ORs are up against (sidebar, p 18).

Though rare, RSIs take a heavy toll. Patients with retained items had a rate of death 2.14% higher than controls, excess hospital stays of 2.08 days, and excess costs of $13,315, in a report by Zhan et al. They also increase liability costs.

Four companies now offer technologies to help in accounting for instruments and sponges. The newest, ORLocate, which entered the market in August 2010, is the first that can account for instruments. The other companies are upgrading their systems.

Role for technology

A role for technology is being recognized in the literature and professional guidelines.

The Mayo Clinic, examining RSIs that occurred in its organization between 2003 and 2006, concluded that manual counting was unreliable as the primary means for avoiding RSIs and that investigating new technologies for achieving reliable counts is warranted (Cima et al, 2008).

AORN's new "Recommended practices for the prevention of retained surgical items" say that adjunct technologies may be considered to supplement manual counts, in addition to improving manual counting methods. The recommendations advocate a multidisciplinary approach to accounting for soft goods, sharps, and instruments plus standardized measures for counting and addressing count discrepancies.

An expert on RSI prevention, surgeon Verna Gibbs, MD, advises caution when considering technology.

"Technology adds another layer to already complex OR systems," she observes. "And technology requires human interface and interaction, which invite new opportunities for error. We also haven't seen how all the new developments will actually work in OR environments. "

She says sponges have been retained with the new systems, "because humans operate the technology.

"Technology is not the answer but can assist with a difficult and persistent problem. It is up to hospitals to look at all the solutions that are out there and find what will work best for them."

Technology is also expensive. Each technology has sponges that are unique to its system and provide the companies with a continuing source of revenue. Once a hospital buys one company's sponges, it can't easily change to another system, Dr Gibbs points out.

Dr Gibbs, developer of the NoThing Left Behind campaign for RSI prevention (www.nothingleftbehind.org), is professor of clinical surgery at the University of California, San Francisco, and a surgeon at the San Francisco Veterans Affairs Medical Center. She has been testing a refined manual counting method, called Sponge ACCOUNTING, which she says is coming up on a year of experience in 40 hospitals with no retained items reported.

Technology update

Here's an update on the 4 companies that have Food and Drug Administration (FDA) clearance for their counting/detection systems.

The systems perform 3 basic types of functions: count sponges, detect sponges, or count and detect sponges and instruments.

Counting and detecting instruments

As the newest technology, ORLocate (www.orlocate.com) counts, tracks, and monitors both surgical instruments and sponges in the OR using radiofrequency identification (RFID).

Each instrument and sponge is tagged with an RFID chip, giving the item a unique identity that tells not only where the item is but which item it is. The system confirms that counts are correct or incorrect, and if a sponge or instrument is missing, which one it is.

The RFID chip, the size of a small hearing aid battery, comes embedded in sterile surgical sponges and can be laser-welded in a ring to existing instruments. A flat surface area of at least 3 mm is needed to attach the chip.

The system also requires trays with detecting antennas for the Mayo stand and back table as well as a kick bucket with antenna, which can read how many and what kind of sponges or instruments are placed on or in them.

Dr Gibbs terms as "revolutionary" the company's ability to attach to instruments an RFID chip that can withstand sterilization.

ORLocate's general manager, Donald Mudd, says a common question the company receives is, "How do you know the chip won't fall off in the sterilizer?" He says the company's laboratory testing shows there have been over a thousand cycles of sterilization of these instruments without failures. "The instrument will have to be replaced before the chip," Mudd says.

The system costs $100,000 per OR, which could be reduced to $70,000, depending on the number of ORs. The company has a mobile lab for retrofitting existing instruments. If a hospital buys 5 OR systems, the company will tag 1,000 instruments at no charge; if 10 systems are purchased, 2,000 instruments will be tagged at no charge. Additional instruments are tagged for a nominal price.

ORLocate expects to pilot its system in January 2011.

Asset management system

ORLocate offers an additional platform for use as an asset management system in sterile processing departments (SPD). Dr Gibbs notes this is a unique attribute of this technology. Because each instrument with a chip has a unique identity, the system can be used to determine which instruments are in which trays and to keep track of instruments needing repair. If an instrument is missing, the system can tell which one. The system can also show how many times an instrument has been used and when it is approaching the end of its life cycle. SPD packing station systems list for $14,500 each; an administrative station lists at $13,500.

Surgical item counting and detection technologies

	Data matrix label	RFID chip	RFID chip	RF tag
Brand name	**SurgiCount Safety Sponge System**	**ORLocate**	**ClearCount Smart-Sponge System**	**RF Assure Detection System**
Web site	www.surgicount medical.com	www.orlocate.com	www.clearcount.com	www.rfsurg.com
Distributor	Cardinal Health		Cardinal Health	Medline Industries
FDA cleared	March 2006	August 2010	June 2007	November 2006
What it does	Counts sponges	Counts/detects instruments/sponges	Counts/detects sponges	Detects sponges
What's new	New model scanning device has improved battery life; brighter, higher resolution screen; and faster processor/imager. Regular software upgrades.	Newest system to enter market is first to count, detect instruments.		New detection mat has radiolucent antennas in a gel pad used to scan entire body at end of case with a touch of a button.
System components	• Bar-coded sponges and towels • Touch-screen scanning device • Database application that allows for review, management, and analysis of counting reports	• Sponges and instruments with RFID chips • Touch-screen console for tracking and monitoring sponges and instruments • Antennas detect and count sponges and instruments used during the case • Locator wand to scan for instruments or sponges • Asset management module available	• Sponges and towels with RFID chips • Scanner reads and records unique ID for each sponge and verifies initial count • Scanner bucket counts sponges and matches ID number of sponges to initial count • Wand to scan body before case is closed when counts don't match	• RF tagged sponges and towels • RF detection console • RF detection mat used to scan body at end of case • Wand to scan linen and trash bins and around sterile field to locate a missing sponge • Reporting capabilities
Cost	$12 per case	$100,000 per OR, could be reduced to $70,000, depending on number of ORs	$10-$13 per procedure	$15 per case
No. of installations	>50 hospitals	Pilot expected to start in January 2011	56 hospitals	>100 hospitals

Note: Cost and installation data provided by companies.

Computer-assisted sponge counting

The SurgiCount Safety-Sponge System (www.surgicountmedical. com) is the only system that uses a 2-dimensional data matrix label to count sponges. A computer-assisted scanner records the unique code embedded in each sponge. The size and flexibility of the data matrix code allow it to be embedded even in tiny neuro patties and tonsil sponges, the company says.

At the end of a case, the system generates a report of the count.

Sponges are scanned and recorded during initial and final counts. Because each sponge has a unique code, the technology will not allow the same sponge to be counted more than once.

The Mayo Clinic in Rochester, Minnesota, has been using the Safety-Sponge System for the past year with no retained sponges identified.

"We concluded that sponges were our biggest problem, and we wanted to add technology to help with the counting," said Robert Cima, MD, MA, vice chairman, department of surgery and associate professor of surgery at the Mayo Clinic. Speaking at the Managing Today's OR Suite Conference in the fall in Orlando, he reported that the technology has reduced total reportable RSIs by nearly 70%.

Notes Dr Gibbs, "We have seen this system being adopted at large single institutions that have a lot of complexity and turnover of residents and nurses."

RFID chip technology

The SmartSponge System (www. clearcount.com), an RFID-based technology, combines sponge counting and detection. The system reads and records a unique identification (ID) number for each sponge during the initial count and provides a 1-to-1 reconciliation in the final count by matching the ID numbers to sponges. The embedded RFID tags are smaller than a dime.

At the beginning of a case, the nurse passes the sponges over a scanner that counts and reads each sponge's ID. The system's LCD screen shows the rolling count.

When surgery is complete, the used sponges are placed in a "smart" bucket that counts each sponge, even if the sponges are stuck together, and the count is displayed on the screen. Because RFID does not require a line of sight between the reader and RFID chips, there is no need to separate sponges or orient the chips in order to scan them, the company says.

"The smart bucket may prove to be a real work saver and safety device for OR nurses, who one day may not have to touch bloody sponges to count them," Dr Gibbs notes.

When initial and final counts don't match, a wand is used to scan the body before the incision is closed to detect if a sponge is present. A light on the wand turns red, and an alarm sounds when the sponge is found. The sponge must be retrieved and added to the bucket to reconcile the final count.

A small 2006 study of an investigational device using this technology by Alex Macario, MD, and colleagues found a detection accuracy of 100% for the wand device.

RF tag technology

RF Surgical Systems, Inc (www. rfsurg.com) has added a new detection mattress system to its sponge detection technology, which uses RF tagged sponges. The company continues to offer a detection wand for locating lost sponges that may be in the trash, linen, or elsewhere in the room.

RF Surgical uses passive low-frequency RF tags, which the company says perform better than RFID chips in fluids and blood, dense tissue, and through bone and metal without interfering with OR equipment. The RF tags have a yes-no signal to indicate whether an item is present but do not have a means to count items.

The new detection mattress contains an array of 6 radiolucent antennas.

The patient lies on the reusable gel mattress, which is covered with a sheet during surgery. At the end of the case, the nurse pushes a button to perform a hands-free scan of the entire body. If an RF-tagged sponge has been left in the patient, an alarm sounds, and a visual display on the console alerts the staff.

"The mattress eliminates human error in the wanding," Victoria M. Steelman, PhD, RN, CNOR, FAAN, told *OR Manager*. Steelman, who is assistant professor in the College of Nursing, University of Iowa Hospital and Clinics, Iowa City, performed a study to find if RF technology could detect sponges through the torso of morbidly obese patients. She found the wand alone had 100% sensitivity if used correctly.

Interim results of a 5-hospital study indicated the RF technology reduced the need for postop x-rays, decreased stress in the OR during closing, and easily identified retained foreign objects. A poster on the study was presented at the American College of Surgeons meeting in Fall 2010 by Christopher Rupp, MD, a surgeon at the University of North Carolina. The study was partly funded by RF Surgical. ❖

—Judith M. Mathias, MA, RN

References

AORN. Recommended practices for the prevention of retained surgical items. *Perioperative Standards and Recommended Practices, 2010 Edition.* Denver, CO: AORN.

Cima R R, Kollengode A, Garnatz J, et al. Incidence and characteristics of potential and actual retained foreign object events in surgical patients. *J Am Coll Surg.* 2008;207:80-87.

Gawande A A, Studdert D M, Orav E J, et al. Risk factors for retained instruments and sponges after surgery. *N Engl J Med.* 2003;348:229-235.

Gibbs V C, Coakley F D, Reines H D. Preventable errors in the operating room: Retained foreign bodies after surgery. *Current Problems Surg.* 2007;44:281-337.

Macario A, Morris D, Morris S. Initial clinical evaluation of a handheld device for detecting retained surgical gauze sponges using radiofrequency identification technology. *Arch Surg.* 2006;141:659-662.

Patterson P. Preventing retained surgical items: What roles does technology play? *OR Manager.* 2009;25(11):1, 8-11.

Zhan C, Miller M R. Excess length of stay, charges, and mortality attributable to medical injuries during hospitalization. *JAMA.* 2003;290:1868-1874.

Some retained items beyond reach of technology

Though technology may help prevent some retained items, it wouldn't have prevented 6 of the 8 events recently reported from California. Eight of the state's hospitals were fined $25,000 to $75,000 in November 2010 for retained items, including:

- 2 sponges
- a blade for a retractor delivered by a sales rep at the last minute

- part of a Guidant Heartstring proximal seal system
- a guidewire
- a non-radiopaque blue towel used to stanch bleeding in an emergency case
- a malleable retractor
- a drill bit.

Under California law, retained items are one of 28 medical errors hospitals must report because they place patients at risk of death or serious injury. The state can issue fines of $50,000 for the first event, $75,000 for the second, and $100,000 for the third or subsequent errors at the same hospital.

The reports are posted at www.cdph.ca.gov/Pages/NR10-87-.aspx

5 top reasons counts are likely to fail

An analysis shows the top 5 causes for potential failures involving manual surgical counts are:

- distraction
- multitasking
- not following procedures
- time pressure
- emergency cases.

The findings are from a failure modes and effects analysis (FMEA) on managing sponges, conducted by Victoria Steelman, PhD, RN, CNOR, FAAN. The study has been accepted for publication by the *AORN Journal.*

Education—the number one intervention after a retained item event—won't fix the problem, she says, because none of the failure modes is related to a knowledge deficit.

Other common strategies used after an event, disciplining the employee or reinforcing the policy, work only 14% of the time, she notes.

Counting is not enough to prevent retained sponges 100% of the time, Steelman notes, and ORs need to start evaluating the available technology for assistance.

"I'm not advocating for one technology over the others," she says. "I'm just saying that it's time we start looking at technology to assist us with this. I think all of the technologies are an improvement over counting alone."

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Professional Education

1963-1967 University of San Francisco
Degree: Bachelor of Science, Nursing

Licenses and Certification

State of California, Registered Nurse, #180821

State of California, Public Health Nurse Certificate

CNOR - Certification in Perioperative Nursing Practice; certified since 1984
Currently inactive

Professional Experience

6/00 – present Sarlatte Consulting - Perioperative Nursing Consultant
Projects include:

- City of Hope Medical Center, Duarte, CA
  Implementation of a Perioperative Information System
- San Mateo Medical Center, San Mateo, CA
  Assessment/Recommendations to increase utilization of perioperative services
- Sutter Medical Center Santa Rosa, Santa Rosa, CA
  Assessment/Recommendations for Perioperative Services
- St. Joseph Health System Sonoma County, Santa Rosa, CA
  Implementation of replacement Periop Information System

6/98 – 6/00 Director, Perioperative Services
Santa Rosa Memorial Hospital
Santa Rosa, CA
With organizational restructuring, retained responsibilities for Perioperative Services (OR, PACU, GI Endoscopy, Outpatient Pavilion); the newly created Director of Laboratory Services assumed responsibility for the Clinical Laboratory and Pathology.

6/96 – 6/98 Director, Perioperative and Laboratory Services
Santa Rosa Memorial Hospital
Santa Rosa, CA
With organizational restructuring, assumed complete personnel and fiscal responsibilities for Clinical Laboratory and Pathology, in addition to Perioperative Director responsibilities. Direct one Chief Laboratory Technologist, with responsibilities for 25 professional and para-professional employees. Work collaboratively with Laboratory Medical Director to assure compliance with all regulatory standards and timely results of laboratory and pathology reports to hospital and Medical Staff.

6/94 - 6/96	Director, Perioperative Services Santa Rosa Memorial Hospital Santa Rosa, CA Title change - Responsibilities remained the same
12/88-6/94	Nurse Manager, Perioperative Services Santa Rosa Memorial Hospital Santa Rosa, CA Department Manager in a decentralized Nursing Service with complete personnel and fiscal responsibility for PACU, inpatient Operating Rooms, outpatient Operating Rooms, AM Admit Unit, and Gastrointestinal endoscopy suites. Direct 5 Assistant Nurse Managers, with responsibilities for 105 professional and para-professional employees, and Materials Coordinator for Perioperative Services.
4/87-12/88	Manager, Outpatient Pavilion Santa Rosa Memorial Hospital Department Manager with complete personnel and fiscal responsibility for outpatient operating rooms, AM Admit Unit, and GI endoscopy. Direct 2 Assistant Nurse Managers, with responsibility for 19 professional and para-professional employees.
5/86-4/87	Acting Director of Nursing, Surgical Services Santa Rosa Memorial Hospital In addition to Nurse Manager responsibilities for Outpatient Pavilion, held administrative responsibility for PACU, OR, and OPP. Directed 2 other Nurse Managers, with personnel and fiscal responsibility for 90 professional and para-professional employees.
1/80-5/86	Director, Outpatient Services Santa Rosa Memorial Hospital Department Manager with complete personnel and fiscal responsibility for outpatient operating rooms and gastrointestinal endoscopy. Direct 2 Charge Nurses, with responsibility for 16 professional and para-professional employees.
1/77-1/80	Clinical Coordinator, Surgical Unit and Surgical Day Care Santa Rosa Memorial Hospital 24-hour personnel and fiscal responsibility for 32 bed inpatient surgical unit and 4-bed outpatient surgical unit
9/74-1/77	Patient Care Coordinator, Surgical and Oncology Units Santa Rosa Memorial Hospital 24-hour personnel responsibility for 32 bed inpatient surgical unit and 33 bed inpatient medical/oncology unit.

5/70-9/74 Staff Nurse II
Santa Rosa Memorial Hospital
Held Staff Nurse positions in Med/Surg, Labor and Delivery, Newborn Nursery, Post-Partum. Acted as relief Charge Nurse in Obstetrics and Med/Surg.

6/67-3/70 Staff Nurse
Hillcrest Hospital
Petaluma, CA
Positions held in Med/Surg, Labor and Delivery, Newborn Nursery, Post-Partum, ICU-CCU. Acted as relief Charge Nurse and night shift Supervisor.

Professional Capabilities

Management and Personnel

- Developed and revised position descriptions
- Evaluated personnel in both staff and management positions in conjunction with performance appraisal and merit increases
- Selected and oriented Assistant Nurse Managers into management roles
- Participated in hospital wide task force to make major revision to performance appraisal tools
- Developed, revised, and updated policies and procedures conforming to JCAHO, Title 22, and AORN standards
- Planned, remodeled and opened an on-campus, free-standing Outpatient Surgery Department
- Facilitated several remodeling projects with experience in conforming to Office of Statewide Health Planning and Development (OSHPD) requirements for the State of California
- Participated in Nursing Division development and implementation of a Professional Practice Model (Shared Governance)
- Chaired Quality Improvement Council and Fiscal Management Council within the Professional Practice Model

Program Development

- Responsible for planning and implementing the pre-admission testing program for surgical patients at Santa Rosa Memorial Hospital (EASE program)
- Developed position description and selected candidate for Perioperative Patient Education position to manage the EASE (Early Admission Surgical Evaluation) program
- Responsible for development of separate Outpatient Surgery Department and GI endoscopy suites
- Researched, developed and implemented an Apheresis Program

Financial Planning and Budget Management

- Managed a $6 million salary and non-salary expense budget for 3 departments and a $1 million capital equipment budget
- Since 1977, have participated in budget preparation and monitoring for department or departments under my supervision (units of service, capital equipment, salary and non-salary expense)
- Worked closely with all physician specialties to plan for and acquire capital equipment
- Review bi-weekly productivity tracking and FTE analysis reports with ANM's

Training and Development

- Trainer for Management and Organization Development Program, Santa Rosa Memorial Hospital
- Developed routine meeting for Lead Specialty Nurses in OR to address issues and communicate expectations of their roles
- Acted as a resource to new Nurse Managers especially relative to organizational skills, QI and fiscal management
- Oriented and mentored new Assistant Nurse Managers in their first management roles

Consultation and Communication

- Developed positive physician relationships by exhibiting behaviors that elicit trust and respect
- Counseled staff on work-related issues, patient care issues, communication problems, and disciplinary issues
- Facilitated staff problem solving utilizing participative management style

Professional Affiliations and Activities

Association of Operating Room Nurses 1979 - present

Redwood Empire Chapter offices held:

Treasurer, 1981-83
President-Elect, 1983-84
President, 1984-85

Chairperson, Educational Seminars:

"Continuing Concepts in PACU Nursing", 1983; "Maxillofacial Surgery Seminar", 1981; "Arthroscopy Seminar", 1981
"Endoscopes: What We're Looking Into", 1992

Delegate or Alternate to AORN National Congress:

1982-1988, 1990, 1992-1998, 2000, 2002, 2004

Operating Room Nursing Council of California (ORNCC)

Associate Member, 1989 to present
Vice Chairman/Treasurer, 1991 to 1993
Chairman, 1994-1996
Secretary, 2002-2004, 2004-2006

Editorial board member, "Journal of Infection Control and Sterilization Technology" 1995 to 1998

Editorial board member, "OR Manager" 1996 -2000

Professional Development

- University of California, San Francisco Medical Center
  Regional Medical Program, Area I Intensive Coronary Care Nursing - 4-week course
- Attended annual AORN Congress 1981 to 2004, except for 4 years
- Attended OR Manager annual meeting 1990, 1991, 1993-2010
- Numerous professional workshops and classes

Publications and Speaking Engagements

Publication:

"Managing the Clinical Laboratory", *Surgical Services Management,* August, 1998, Volume 4 Number 8, pp. 30-33

Speaking Engagements:

Managing Today's OR Suite, 1997, "Competencies for Management of the Operating Room" Co-presenter with Fernsebner and Cofield; presented in San Diego, CA and Chicago, IL (Breakout Session – 2.5 hours; approximately 180 attendees)

"Quality Assurance" Sole presenter for an all day seminar designed for Nurses (staff and management). February, 1995, Santa Rosa, California (Approximately 80 attendees)

"New Advances in Arthroscopic Surgery" Daylong seminar sponsored by AORN of the Redwood Empire, 1985, Santa Rosa, California. Presenter of 1 two-hour section.

Trainer for Management Organization and Development program held on an ongoing basis at Santa Rosa Memorial Hospital for Management Staff. Periodically provided 1-2 day seminars for new and existing management staff on a variety of topics. These seminars were done in conjunction with 2 other trainers. Usual group size: 20-30 participants.

BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.2
DATE: April 13, 2011

ACTION REQUESTED: Registered Nurse Advisories

REQUESTED BY: Judy L. Corless, BSN, RN, Chairperson
Nursing Practice Committee

BACKGROUND:
At the Board's January 2, 2011 the Practice Committee was requested to have legal counsel review the following advisories for acceptance:

- Abandonment of Patients
- Nursing Student Workers
- Reproductive Privacy Act

Legal had opportunity to review the Registered Nurse Advisories and provide changes as determined. The above advisories are now available for the practice committee's review, the updated advisories are attached and deleted advisories are attached.

The following are changes and or no changes to the above advisories
Abandonment of Patient…addition of term "generally" added in bold
Nursing Student Worker…no addition or changes.
Reproductive Privacy Act…addition in bold.

NEXT STEPS: Board

FISCAL IMPLICATIONS, IF ANY: None

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Louise R. Bailey, MEd, RN, Executive Officer

ABANDONMENT OF PATIENTS

Inquiries have been received by the Board of Registered Nursing (BRN) regarding which actions by a nurse constitute patient abandonment and thus may lead to discipline against a nurse's license.

Generally for patient abandonment to occur, the nurse must:

a) Have first **accepted** the patient assignment, thus establishing a nurse-patient relationship, and then

b) **Severed** that nurse-patient relationship without giving reasonable notice to the appropriate person (e.g., supervisor, patient) so that arrangements can be made for continuation of nursing care by others.

A nurse-patient relationship **generally** begins when responsibility for nursing care of a patient is accepted by the nurse. Failure to notify the employing agency that the nurse will not appear to work an assigned shift is not considered patient abandonment by the BRN, nor is refusal to accept an assignment considered patient abandonment. Once the nurse has accepted responsibility for nursing care of a patient, severing of the nurse-patient relationship without reasonable notice may lead to discipline of a nurse's license.

RNs must exercise critical judgment regarding their individual ability to provide safe patient care when declining or accepting requests to work overtime. A fatigued and/or sleep deprived RN may have a diminished ability to provide safe, effective patient care. Refusal to work additional hours or shifts would not be considered patient abandonment by the BRN.

The RN who follows the above BRN advisory statement will not be considered to have abandoned the patient for purposes of Board disciplinary action. However, it should be noted that the BRN has no jurisdiction over employment and contract issues.

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NURSING STUDENT WORKERS

A student nurse worker may not perform nursing functions beyond the level of a nursing assistant unless enrolled in a BRN approved Work Study Course in a California approved prelicensure nursing program.

Background:

The Nursing Practice Act permits students enrolled in a Board approved prelicensure nursing program to render registered nursing services when these services are incidental to a course of study in the program (Business and Professions Code 2729 (a)). A work-study course offered by a nursing program complies with this section of law and provides additional clinical experiences for student nurses admitted to and enrolled in its own nursing program. With a work-study program, nursing students are exposed to the realities of the clinical environment and have the opportunity to master learned skills. Additionally, clinical agencies benefit by the student nurse's skills and have the opportunity to attract new graduate nurses to their facility.

Work-Study Program

The nursing programs in California are responsible for following the Board's guidelines in developing a work-study course as follows:

1) Nursing program develops a course in which previously learned nursing theory and clinical skills are applied
   - A student must have acquired clinical competence in these skills. A list of skills competencies are provided to the clinical agency (work-study site).
   - No new skills may be taught during this course
   - Hours of instruction for the course follow the formula per CCR 1426(g)(2)
   - A course faculty of record is available and is responsible for ongoing communication with students and agency and monitoring the student.

2) Nursing program develops an agreement with a clinical agency with which it has a contract, to provide a work-study course for which a student receives academic credit. Compensation of the student by the practice site is encouraged.

3) The clinical agency agrees to the objectives of the course and provides mentors or preceptors for direct supervision of students.

4) The instructor and agency mentors meet at regular intervals to discuss student progress and jointly share in the evaluation of the student.

5) The course instructor has the final responsibility to evaluate and grade students and their mastery of the course objectives.

Approval of work-study program

- All work-study courses require Board approval prior to course implementation.
- Nursing program submits a minor curriculum revision request to the assigned nursing education consultant following the curriculum revision guidelines.

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GUIDELINES FOR WORK STUDY COURSES

Background:
The Nursing Practice Act permits students enrolled in a Board approved prelicensure nursing program to render registered nursing services when these services are incidental to a course of study in the program (Business & Professions Code Section 2729[a]). A work-study course offered by a nursing program complies with this section of the law and provides additional clinical experiences for student nurses admitted to and enrolled in its own nursing program. With a work-study program, nursing students are exposed to the realities of the clinical environment and have the opportunity to master learned skills. Additionally, clinical agencies benefit by the student nurse's skills and have the opportunity to attract new graduate nurses to their facility.

Guidelines to develop a work-study course are as follows:

1) Nursing program develops a course in which previously learned nursing theory and clinical skills are applied.
   - A student must have acquired clinical competence in these skills. A list of skills competencies is provided to the clinical agency (work-study site).
   - No new skills may be taught during this course.
   - Hours of instruction for the course follow the formula per CCR 1426(g)(2).
   - A course faculty of record is available and is responsible for ongoing communication with students and agency and monitoring of student progress.

2) Nursing program develops an agreement with a clinical agency with which it has a contract, to provide a work-study course for which a student receives academic credit. Compensation of the student by the practice site is encouraged.

3) The clinical agency agrees to the objectives of the course and provides mentors or preceptors for direct supervision of students.

4) The instructor and agency mentors meet at regular intervals to discuss student progress and jointly share in the evaluation of the student.

5) The course instructor has the final responsibility to evaluate and grade students and their mastery of the course objectives.

Approval of work-study course:
- All work-study courses require Board approval prior to course implementation.
- Nursing program submits a minor curriculum revision request to the assigned nursing education consultant following the Curriculum Revision Guidelines (EDP-R-09).

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STUDENT WORKERS

A student nurse worker may not perform nursing functions beyond the level of a nursing assistant unless enrolled in a BRN approved student-worker course developed through collaboration of a Board approved nursing program and the health care facility employing the student.

In order to determine which functions such student workers and other nursing assistants may perform, first consider the following definition from the Nursing Practice Act:

> The practice of nursing means those functions, including basic health care, which
>
> (1) help people cope with difficulties in daily living,
>
> (2) are associated with their actual or potential health or illness problems or the treatment thereof,
>
> (3) require a substantial amount of scientific knowledge or technical skill.

As a general operating principle, basic health care functions which possess the first two characteristics may be performed by nursing assistants; functions which possess the third characteristic may not be performed by nursing assistants.

A few examples of functions possessing the third characteristic, i.e., require a substantial amount of scientific knowledge or technical skill, are nasogastric and gastrostomy feedings, tracheostomy care, catheterization, regulation of intravenous infusions and administration of drugs.

Although the mechanics of performing such procedures may be taught quite easily, the ability to assess the patient before and throughout the procedure and to respond appropriately to the patient's reactions derives from additional substantial scientific knowledge and technical skill, and for these reasons are excluded from the practice of unlicensed nurses.

The Attorney General, recently asked if certified nursing assistants can lawfully perform nasogastric or gastrostomy feeding, concluded that they may not. This conclusion was based on a review of the steps for performing the procedures and consideration of the potential for complications, such as the introduction of fluid into the patient's lungs with consequent patient harm. Nursing management may use this same process to make a determination regarding the suitability of assigning a function to a non-nurse.

Nursing management should be aware that the BRN

- holds nursing management responsible for making nursing assignments in accord with the Nursing Practice Act;
- investigates all reports/complaints of unlicensed nursing activity; and
- when evidence supports charges that a registered nurse has assigned a nursing assistant to perform registered nursing functions, takes appropriate disciplinary action against the responsible registered nurse.

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REPRODUCTIVE PRIVACY ACT

Website: http://leginfo.ca.gov/
Effective January 1, 2003: Health and Safety Code 123460

The Reproductive Privacy Act (**Health and Safety Code 123460 et seq**) provides that every individual possesses a fundamental right to privacy with respect to reproductive decisions, including (A) the fundamental right to choose or refuse birth control, and (B) the fundamental right to choose to bear children or obtain an abortion. This new law provides that the state shall not deny or interfere with woman's fundamental right to choose to bear a child or obtain an abortion prior to viability of the fetus, as defined, or when necessary to protect her life and health.

Business and Professions Code section 2253 permits a person to assist in performing a surgical abortion if he or she has a license that authorizes the performance of such activity.

The BRN's interpretation is that the registered nurse, certified nurse practitioner, or certified nurse-midwife may perform the nursing functions necessary to assist with a surgical abortion.

Business and Professions Code section 2253 permits a person to perform or assist in performing the functions necessary for a nonsurgical abortion if he or she has a license that authorizes the performance of such activity.

The BRN's interpretation is that the registered nurse may perform or assist in performing the functions necessary for a nonsurgical abortion including medication administration and patient teaching.

The nurse practitioner or nurse-midwife may perform or assist in performing functions necessary for nonsurgical abortion by furnishing or ordering medications in accord with his or her approved standardized procedures.

The Reproductive Privacy Act includes the following definitions:

"Abortion" means any medical treatment intended to induce the termination of a pregnancy except for the producing of a live birth.

"Pregnancy" means the human reproductive process, beginning with the implantation of an embryo.

"State" means the State of California, and every county, city, town and municipal corporation, and quasi-municipal corporation in the state.

"Viability" means the point in a pregnancy when, in the good faith medical judgment of a physician, on the particular facts of the case before that physician, there is a reasonable likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures.

The performance of an abortion is unauthorized if either of the following is true:

- The person performing or assisting in performing the abortion is not a health care provider authorized to perform or assist in performing an abortion pursuant to Section 2253 of the Business and Professions Code.
- The abortion is performed on a viable fetus, and both of the following are established.
  - In the good faith medical judgment of the physician, the fetus was viable.
  - In the good faith medical judgment of the physician, continuation of the pregnancy posed no risk to life or health of the pregnant woman.

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REPRODUCTIVE PRIVACY ACT

Website: http://leginfo.ca.gov/

Effective January 1, 2003

Senate Bill 1301 (Kuehl), Chapter 385, was signed by Governor Gray Davis on September 5, 2002. The Reproductive Privacy Act provides that every individual possesses a fundamental right to privacy with respect to reproductive decisions, including (A) the fundamental right to choose or refuse birth control, and (B) the fundamental right to choose to bear children or obtain an abortion. This new law provides that the state shall not deny or interfere with woman's fundamental right to choose to bear a child or obtain an abortion prior to viability of the fetus, as defined, or when necessary to protect her life and health.

The Reproductive Privacy Act deletes the provisions of the Therapeutic Abortion Act including the name of the act.

The Reproductive Privacy Act enacts changes to the Business and Professions Code, Section 2253 to allow registered nurses, certified nurse practitioners, certified nurse-midwives with valid, unrevoked, and unsuspended licenses or certificates to assist in the performance of a surgical abortion and to assist in the performance of non-surgical abortion.

The BRN's interpretation is that the registered nurse, certified nurse practitioner, or certified nurse-midwife may perform the nursing functions necessary to assist with a surgical abortion.

The BRN's interpretation is that the registered nurse may perform or assist in performing the functions necessary for a nonsurgical abortion including medication administration and patient teaching.

The nurse practitioner or nurse-midwife may perform or assist in performing functions necessary for nonsurgical abortion by furnishing or ordering medications in accord with his or her approved standardized procedures.

The Reproductive Privacy Act includes the following definitions:

"Abortion" means any medical treatment intended to induce the termination of a pregnancy except for the producing of a live birth.

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"State" means the State of California, and every county, city, town and municipal corporation, and quasi-municipal corporation in the state.

"Viability" means the point in a pregnancy when, in the good faith medical judgment of a physician, on the particular facts of the case before that physician, there is a reasonable likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures.

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- The person performing or assisting in performing the abortion is not a health care provider authorized to perform or assist in performing an abortion pursuant to Section 2253 of the Business and Professions Code.
- The abortion is performed on a viable fetus, and both of the following are established.
  - In the good faith medical judgment of the physician, the fetus was viable.
  - In the good faith medical judgment of the physician, continuation of the pregnancy posed no risk to life or health of the pregnant woman.

BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.3
DATE: April 13, 2011

ACTION REQUESTED: Nurse Practitioner Advisories

REQUESTED BY: Judy L. Corless, BSN, RN, Chairperson
Nursing Practice Committee

BACKGROUND:
Legal had opportunity to review the Nurse Practitioner Advisories and provide changes as determined. The above advisories are now available for the practice committee's review, the updated advisories are attached and deleted advisories are attached.

The advisories relate to Nurse Practitioner Practice:

- Clinic's Eligible for Licensure
- General Information: Nurse Practitioner Practice
- Nurse Practitioner in Long-Term Care

Advisory titled General Information: Nurse Practitioner Practice is based on the Nursing Practice Act and California laws enacted pertinent to nurse practitioner practice. The updating includes incorporation of previous advisories marked as deleted.

Nurse Practitioner in Long Term Care Settings extracted from Welfare and Institutions Code and is on page 303 -304 in 2011 Edition California Nurse Practice Act with Regulations and Related Statutes. The updating deleted previous advisory NP in Long Term Care Setting.

Clinic's Eligible for Licensure extracted from Health and Safety Code and is on page 241-243 in the 2011 Edition of the California Nurse Practice Act with Regulations and Related Statutes. The above on clinics is added to NP advisories and it was not previously listed in the NP advisories.

The Practice Committee may direct staff to forward NP advisories to the Board for approval at their next meeting and if approved by the Board post the NP advisories on the BRN Website.

NEXT STEPS: Board

FISCAL IMPLICATIONS, IF ANY: None

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CLINIC'S ELIGIBLE FOR LICENSURE

Website: http://leginfo.ca.gov/cgi-bin/calawquery?codesection=hsc&codebody=1204&hits=20

Extracted from Health and Safety Code
Division 2
Licensing Provisions
Chapter 1
Clinics
Article 1
Definitions and General Provisions

1204. Clinics eligible for licensure

Clinics eligible for licensure pursuant to this chapter are primary care clinics and specialty clinics.

(a) (1) Only the following defined classes of primary care clinics shall be eligible for licensure:

(A) A "community clinic" means a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions that may be in the form of money, goods, or services. In a community clinic, any charges to the patient shall be based on the patient's ability to pay, utilizing a sliding fee scale. No corporation other than a nonprofit corporation, exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a community clinic; provided, that the licensee of any community clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a community clinic.

(B) A "free clinic" means a clinic operated by a tax-exempt, nonprofit corporation supported in whole or in part by voluntary donations, bequests, gifts, grants, government funds or contributions that may be in the form of money, goods, or services. In a free clinic there shall be no charges directly to the patient for services rendered or for drugs, medicines, appliances, or apparatuses furnished. No corporation other than a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a free clinic; provided, that the licensee of any free clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a free clinic.

(2) Nothing in this subdivision shall prohibit a community clinic or a free clinic from providing services to patients whose services are reimbursed by third-party payers, or from entering into managed care contracts for services provided to private or public health plan subscribers, as long as the clinic meets the requirements identified in subparagraphs (A) and (B). For purposes of this subdivision, any payments made to a community clinic by a third party payer, including, but not limited to, a health care service plan, shall not constitute a charge to the patient. This paragraph is a clarification of existing law.

(b) The following types of specialty clinics shall be eligible for licensure as specialty clinics pursuant to this chapter:

(1) A "surgical clinic" means a clinic that is not part of a hospital and that provides ambulatory surgical care for patients who remain less than 24 hours. A surgical clinic does not include any place or establishment owned or leased and operated as a clinic or office by one or more physicians or dentists in individual or group practice, regardless of the name used publicly to identify the place or establishment, provided, however, that physicians or dentists may, at their option, apply for licensure.

(2) A "chronic dialysis clinic" means a clinic that provides less than 24-hour care for the treatment of patients with end-stage renal disease, including renal dialysis services.

(3) A "rehabilitation clinic" means a clinic that, in addition to providing medical services directly, also provides physical rehabilitation services for patients who remain less than 24 hours. Rehabilitation clinics shall provide at least two of the following rehabilitation services: physical therapy, occupational therapy, social, speech pathology, and audiology services. A rehabilitation clinic does not include the offices of a private physician in individual or group practice.

(4) An "alternative birth center" means a clinic that is not part of a hospital and that provides comprehensive perinatal services and delivery care to pregnant women who remain less than 24 hours at the facility.

1204.3. Alternative birth centers

(a) An alternative birth center that is licensed as an alternative birth center specialty clinic pursuant to paragraph (4) of subdivision (b) of Section 1204 shall, as a condition of licensure, and a primary care clinic licensed pursuant to subdivision (a) of Section 1204 that provides services as an alternative birth center shall, meet all of the following requirements:

(1) Be a provider of comprehensive perinatal services as defined in Section 14134.5 of the Welfare and Institutions Code.

(2) Maintain a quality assurance program.

(3) Meet the standards for certification established by the National Association of Childbearing Centers, or at least equivalent standards as determined by the state department.

(4) In addition to standards of the National Association of Childbearing Centers regarding proximity to hospitals and presence of attendants at births, meet both of the following conditions:

(A) Be located in proximity, in time and distance, to a facility with the capacity for management of obstetrical and neonatal emergencies, including the ability to provide cesarean section delivery, within 30 minutes from time of diagnosis of the emergency.

(B) Require the presence of at least two attendants at all times during birth, one of whom shall be either a physician and surgeon or a certified nurse-midwife.

(5) Have a written policy relating to the dissemination of the following information to patients:

(A) A summary of current state laws requiring child passenger restraint systems to be used when transporting children in motor vehicles.

(B) A listing of child passenger restraint system programs located within the county, as required by Section 27360 of the Vehicle Code or Section 27362 of that code.

(C) Information describing the risks of death or serious injury associated with the failure to utilize a child passenger restraint system.

(b) The state department shall issue a permit to a primary care clinic licensed pursuant to subdivision (a) of Section 1204 certifying that the primary care clinic has met the requirements of this section and may provide services as an alternative birth center. Nothing in this section shall be construed to require that a licensed primary care clinic obtain an additional license in order to provide services as an alternative birth center.

(c) (1) Notwithstanding subdivision (a) of Section 1206, no place or establishment owned or leased and operated as a clinic or office by one or more licensed health care practitioners and used as an office for the practice of their profession, within the scope of their license, shall be represented or otherwise held out to be an alternative birth center licensed by the state unless it meets the requirements of this section.

(2) Nothing in this subdivision shall be construed to prohibit licensed health care practitioners from providing birth related services, within the scope of their license, in a place or establishment described in paragraph (1).

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GENERAL INFORMATION: NURSE PRACTITIONER PRACTICE

Scope of Practice

The nurse practitioner (NP) is a registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, who has been prepared in a program that conforms to Board standards as specified in, Title 16 California Code of Regulations, (CCR), 1484 Standards of Education.

Primary Health Care

Primary health care is defined as, that which occurs when a consumer makes contact with a health care provider, who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease, Title 16 CCR 1480 (b). This means that, in some cases, the NP will be the only health professional to see the patient and, in the process, will employ a combination of nursing and medical functions approved by standardized procedures.

Clinically Competent

Clinically competent means that one possess and exercises the degree of learning, skill, care ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice, (Title 16 CCR 1480 c)

Legal Authority for Practice

The NP does not have an additional scope of practice beyond the usual RN scope and must rely on standardized procedures for authorization to perform overlapping medical functions, (Title 16 CCR Section 1485). Business and Professions Code (BPC) Section 2725 provides authority for nursing functions that are also essential to providing primary health care which do not require standardized procedures. Examples include physical and mental assessment, disease prevention and restorative measures, performance of skin tests and immunization techniques, and withdrawal of blood, as well as authority to initiate emergency procedures.

Nurse practitioners frequently ask if they really need standardized procedures. The answer is that they do when performing overlapping medical functions. Standardized procedures are the legal authority to exceed the usual scope of RN practice. Without standardized procedures the NP is legally very vulnerable, regardless of having been certified as a RN, who has acquired additional skills as a certified nurse practitioner.

Certification

Registered nurses who have been certified as NPs by the California Board of Registered Nursing may use the title nurse practitioner and place the letters “R.N., N.P.” after his/her name alone or in combination with other letters or words identifying categories of specialization,

including but not limited to the following: adult nurse practitioner, pediatric nurse practitioner, obstetrical-gynecological nurse practitioner, and family nurse practitioner. (Title 16 CCR 1481)

On and after January 1, 2008, an applicant will be required for initial qualification or certification as a nurse practitioner who has never been qualified or certified as a nurse practitioner in California or in any other state to meet specified requirements, including possessing a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the board. (BPC 2835.5)

Furnishing Drugs and Devices
BPC Code Section 2836.1 authorizes NPs to obtain and utilize a "furnishing number" to furnish drugs and devices. Furnishing or ordering drugs and devices by the nurse practitioner is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure. Furnishing is carried out according to a standardized procedure and a formulary may be incorporated. All nurse practitioners who are authorized pursuant to Section 2836.1 to furnish or issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration.

BPC 2836.1 was amended changing furnishing to include "order" for a controlled substance, and can be considered the same as an "order" initiated by the physician. This law requires the NP who has a furnishing number to obtain a DEA number to "order" controlled substances, Schedule II, III, IV, V. (AB 1545 Correa) stats 1999 ch 914 and (SB 816 Escutia) stats 1999 ch 749.

Furnishing Controlled Substances:
The furnishing or ordering of drugs and devices occurs under physician and surgeon supervision. B&P Code Section 2836.1 the NP who is registered with the United States Drug Enforcement Administration, the furnishing authority or "order" can include Schedule II through V Controlled Substances under the Uniform Controlled Substance Act . There are specified educational requirements that must be met by the furnishing NP who wishes to "order" Schedule II Controlled Substances.

Drugs and/or devices furnished or "ordered" by a NP may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 commencing with Section 11000) of the Health and Safety Code and shall be further limited to those drugs agreed upon by the NP and physician and specified in the standardized procedure.

When Schedule II or III controlled substances, as defined in Section 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a NP, the controlled substance shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. The provision for furnishing Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is to be furnished. A copy of the section for the NP's standardized procedure relating to controlled substances shall be provided upon request to any licensed pharmacist who dispenses drugs or devices when there is uncertainty about the furnishing transmittal order.

The nurse practitioner with an active furnishing number, who is authorized by standardized procedure or protocols to furnish must submit to the BRN an approved course that includes Schedule II Controlled Substances content as a part of the NP educational program or a continuing educational course with required content on Schedule II Controlled substance. The proof of a Schedule II course received by the BRN will be noticed on the board's website, www.rn.ca.gov, in the NPF verification section.

A prescription pad may be used as transmittal order forms as long as they contain the furnisher's name and furnishing number. Pharmacy law requires the nurse practitioner name on the drug and/or device container label. The name of the supervising physician is no longer required on the drug/device container label as pharmacy law was amended BPC 1470 (f). The nurse practitioner DEA number is required for controlled substances. Therefore, inclusion of this information on the transmittal order form will facilitate dispensing of the drug and/or device by the pharmacist.

Dispensing Medication
Business and Professions Code Section 2725.1 allows registered nurses to dispense (hand to a patient) medication except controlled substances upon the valid order of a physician in primary, community, and free clinic. Business and Professions Code Section 2725.1 grants to the furnishing nurse practitioner authority to dispense drugs, including controlled substances, pursuant to standardized procedures or protocols in primary, community, and free clinics.

Effective January 1, 2003, B&P Code Section 2836.1 was amended to allow NPs to use their furnishing authority in solo practice per Senate Bill 933 (Figueroa) Chapter 764 signed by Governor Gray Davis on September 20, 2002.

Authorized Standardized procedures
Added in legislative session 2003 ch 308 § 34 (SB 819), effective January 1, 2010

2835.7. (a) Notwithstanding any other provision of law, in addition to any other practices that meet the general criteria set forth in statute or regulation for inclusion in standardized procedures developed through collaboration among administrators and health professionals, including physicians and surgeons and nurses, pursuant to Section 2725, standardized procedures may be implemented that authorize a nurse practitioner to do any of the following:
(1) Order durable medical equipment, subject to any limitations set forth in the standardized procedures. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.
(2) After performance of a physical examination by the nurse practitioner and collaboration with a physician and surgeon, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.
(3) For individuals receiving home health services or personal care services, after consultation with the treating physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.
(b) Nothing in this section shall be construed to affect the validity of any standardized procedures in effect prior to the enactment of this section or those adopted subsequent to enactment.

Sign for the Request and Receipt of Pharmaceutical Samples and Devices.
Certified furnishing nurse practitioners are authorized to sign for the request and receipt of complimentary samples of dangerous drugs and devices identified in their standardized procedures or protocols that have been approved by the physician. (B&P Code Section 4061 of the Pharmacy)

Treating STDs
Section 120582 of the Health and Safety Code:

(a) Not withstanding any other provision of law, a physician and surgeon who diagnoses a sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services, in an individual patient may prescribe, dispense, furnish, or otherwise provide a prescription antibiotic drugs to the patients sexual partner or partners without examination of that patient's partners.

(b) Not withstanding any other provision a nurse practitioner practicing pursuant to BPC Section 2836.1; a certified nurse-midwife practicing pursuant to BPC Section 2746.51; and a physician assistant pursuant to BPC 3502.1 may dispense, furnish, or otherwise provide a prescription antibiotic drug to the sexual partner or partners of a patient with a diagnosed sexually transmitted Chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services without examination of the patient's sexual partners. (AB 2280 Leno stats 2006 ch) (AB 648 Ortiz stats 2001 ch 835)

Workers' Compensation Reports
Labor Code section 3209.10 gives nurse practitioners the ability to cosign Doctor's First Report of Occupational Injury or illness for a worker's compensation claim to receive time off from work for a period not to exceed three (3) calendar days if that authority is included in standardized procedure or protocols. The treating physician is required to sign the report and to make a determination of any temporary disability.

Veterans with Disabilities Parking Placards:
Vehicle Code section 5007, 9105, 22511.55 includes nurse practitioners, nurse midwives and physician assistants as authorized health care professionals that can sign the certificate substantiating the applicant's disability for the placard.

Existing law authorizes the Department of Motor Vehicles to issue placards to persons with disabilities and veteran with disabilities and temporary distinguishing placards to temporary disabled persons, to be used for parking purposes. Prior to issuing the parking placard or temporary placard, the Department of Motor Vehicles requires the submission of a certificate, signed by an authorized health care professional providing a full description substantiating the applicant's disability, unless the disability is readily observable and uncontested. Under existing law, the authorized health care professional that signs the certificate is required to retain information sufficient to substantiate the certificate, and make the information available to certain entities request of the department.

Medical Examination School Bus Drivers
Vehicle Code Section 12517.2 (a) relating to schoolbus drivers driver medical examination to Applicants for an original or renewal certificate to drive a schoolbus, school pupil activity bus, youthbus, general public paratransit vehicle, or farm labor vehicle shall submit a report of medical examination of the applicant given not more than two years prior to the date of the

application by a physician licensed to practice medicine , a licensed advanced practice nurse qualified to perform a medical examination, or a licensed physician assistant. The report shall be on a form approved by the department, the Federal Highway Administration, or the Federal Aviation Administration.

Schoolbus drivers, within the same month or reaching 65 years of age and each 12th month thereafter, shall undergo a medical examination, pursuant to Section 12804.9, shall submit a report of the medical examination on a form specified in subsection (a) (AB 139 Bass stats 2007, ch 158)

Informing patient: Positive and Negative aspects of Blood Transfusions
Section 1645 of the Health and Safety Code authorizes the nurse practitioner and the nurse-midwife who is authorized to give blood to provide the patient with information by means of a standardized written summary as developed or revised by the State Department of Public Health about the positive and negative aspects of receiving autologous blood and direct and nondirected homologous blood to volunteers. (SB 102 Migden stat 2007 ch 88)

Existing law requires, whenever there is reasonable possibility, as determined by a physician, that a blood transfusion may be necessary as a result of medical procedures, that the physician, by means of a standardized written summary that is published by the Medical Board and now by the Department of Public Health and distributed upon request, inform the patient of the positive and negative aspects of receiving autologous blood and directed and non directed homologous blood from volunteers.

Medi-Cal Billing: Nurse Practitioner Nationally Certified in a Specialty
Section 14132. 41 of the Welfare and Institutions Code provide that services rendered by a certified nurse practitioner shall be covered under this chapter to the extent authorized by federal law, and subject to utilization controls. The department shall permit a (nationally) certified nurse practitioner to bill Medi-Cal independently for his or her services. If a certified (nationally) nurse practitioner chooses to bill Medi-Cal independently for his or her service, the department shall make payment directly to the certified (nationally) nurse practitioner. For the purposes of this section, “certified” means nationally board certified in a recognized specialty.

Supervision
Supervision of the NP performing an overlapping medical function is addressed in the standardized procedure and may vary from one procedure to another depending upon the judgment of those developing the standardized procedure. As an example, in one women’s clinic the supervision requirement for performing a cervical biopsy was that a physician must be physically present in the facility, immediately available in case of emergency. For all other standardized procedure functions, the supervision requirement was for a clinic physician to be available by phone.

The furnishing or ordering of drugs and devices by nurse practitioners occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time the patient is being examined by the nurse practitioner. For furnishing purposes, the physician may supervise a maximum of no more than four (4) NPs at one time. (BPC 2836.1)

Supervision of Medical Assistants
Medical Board of California link for medical assistant
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Business & Profession Code Section 2069(a)(1) and Health & Safety Code 1204 provides that a supervising physician and surgeon at a community clinic or free clinic as licensed pursuant to Health and Safety Code 1204 may, at his or her discretion, in consultation with the nurse practitioner, nurse-midwife, or physician assistant provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. The written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, nurse-midwife, or physician assistant and that tasks may be performed when the supervising physician and surgeon are not on site. This delegation to the nurse practitioner or nurse midwife is limited to those licensed clinics under Health and Safety 1240.

Citation and Fine
NPs, like all registered nurses, are subject to citation and fine for violation of the Nursing Practice Act (NPA). Citation and fines are a form of disciplinary action against the RN license and/or certificate. Examples of violations which have resulted in citation and fine are using the title “nurse practitioner” without being certified as a NP by the California BRN and failing to have standardized procedures when performing overlapping medical functions. NPs are encouraged to comply with all sections of the NPA to avoid discipline.

References
B&P Code, Section 2725 RN Scope of Practice, Section 2834 Nurse Practitioner, California Code of Regulation Section 1435 Citations and Fines, Section 1470 Standardized Procedure Guidelines, Section 1480 Standards for Nurse Practitioners.

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GENERAL INFORMATION: NURSE PRACTITIONER PRACTICE

Scope of Practice

The nurse practitioner (NP) is a registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, who has been prepared in a program that conforms to Board standards as specified in California Code of Regulations, CCR, 1484 Standards of Education.

Primary Health Care

Primary health care is defined as, that which occurs when a consumer makes contact with a health care provider, who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease CCR 1480 (b). This means that, in some cases, the NP will be the only health professional to see the patient and, in the process, will employ a combination of nursing and medical functions approved by standardized procedures.

Clinically Competent

Clinically competent means that on possess and exercises the degree of learning, skill, care ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice (CCR 1480 c)

Legal Authority for Practice

The NP does not have an additional scope of practice beyond the usual RN scope and must rely on standardized procedures for authorization to perform overlapping medical functions (CCR Section 1485). Section 2725 of the Nursing Practice Act (NPA) provides authority for nursing functions that are also essential to providing primary health care which do not require standardized procedures. Examples include physical and mental assessment, disease prevention and restorative measures, performance of skin tests and immunization techniques, and withdrawal of blood, as well as authority to initiate emergency procedures.

Nurse practitioners frequently ask if they really need standardized procedures. The answer is that they do when performing overlapping medical functions. Standardized procedures are the legal authority to exceed the usual scope of RN practice. Without standardized procedures the NP is legally very vulnerable, regardless of having been certified as a RN, who has acquired additional skills as a certified nurse practitioner.

Certification

Registered nurses who have been certified as NPs by the California Board of Registered Nursing may use the title nurse practitioner and place the letters “R.N., N.P.” after his/her name alone or in combination with other letters or words identifying categories of specialization,

including but not limited to the following: adult nurse practitioner, pediatric nurse practitioner, obstetrical-gynecological nurse practitioner, and family nurse practitioner. (CCR 1481)

On and after January 1, 2008, an applicant will be required for initial qualification or certification as a nurse practitioner who has never been qualified or certified as a nurse practitioner in California or in any other state to meet specified requirements, including possessing a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the board. (Business and Professions Code 2835.5)

Furnishing Drugs and Devices
BPC Code Section 2836.1 authorizes NPs to obtain and utilize a "furnishing number" to furnish drugs and devices. Furnishing or ordering drugs and devices by the nurse practitioner is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure. Furnishing is carried out according to a standardized procedure and a formulary may be incorporated. All nurse practitioners who are authorized pursuant to Section 2831.1 to furnish or issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration.

BPC 2836.1 was amended changing furnishing to mean "order" for a controlled substance, and can be considered the same as an "order" initiated by the physician. This law requires the NP who has a furnishing number to obtain a DEA number to "order" controlled substances, Schedule II, III, IV, V. (AB 1545 Correa) stats 1999 ch 914 and (SB 816 Escutia) stats 1999 ch 749.

Furnishing Controlled Substances:
The furnishing or ordering of drugs and devices occurs under physician and surgeon supervision. B&P Code Section 2836.1 extends the NP, who is registered with the United States Drug Enforcement Administration, the furnishing authority or "ordering" to include Schedule II through V Controlled Substances under the Uniform Controlled Substance Act (AB 1196 Montanez) Stats2004 ch 205 § (AB 2560) There are specified educational requirements that must be met by the furnishing NP who wishes to "order" Schedule II Controlled Substances.

Drugs and/or devices furnished or "ordered" by a NP may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 commencing with Section 11000) of the Health and Safety Code and shall be further limited to those drugs agreed upon by the NP and physician and specified in the standardized procedure.

When Schedule II or III controlled substances, as defined in Section 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a NP, the controlled substance shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. The provision for furnishing Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is to be furnished. A copy of the section for the NP's standardized procedure relating to controlled substances shall be provided upon request to any licensed pharmacist who dispenses drugs or devices when there is uncertainty about the furnishing transmittal order.

The nurse practitioner with an active furnishing number, who is authorized by standardized procedure or protocols to furnish must submit to the BRN an approved course that includes Schedule II Controlled Substances content as a part of the NP educational program or a continuing educational course with required content on Schedule II Controlled substance. The proof of a Schedule II course received by the BRN will be noticed on the board's website, www.rn.ca.gov, in the NPF verification section.

A prescription pad may be used as transmittal order forms as long as they contain the furnisher's name and furnishing number. Pharmacy law requires the nurse practitioner name on the drug and/or device container label. The name of the supervising physician is no longer required on the drug/device container label as pharmacy law was amended BPC 1470 (f) (AB 2660 Leno) stats 2004 ch 191. The nurse practitioner DEA number is required for controlled substances. Therefore, inclusion of this information on the transmittal order form will facilitate dispensing of the drug and/or device by the pharmacist.

Dispensing Medication

Business and Professions Code Section 2725.1 allows registered nurses to dispense (hand to a patient) medication except controlled substances upon the valid order of a physician in primary, community, and free clinic.
Business and Professions Code Section 2725.1 was amended to extend to the furnishing nurse practitioner authority to dispense drugs, including controlled substances, pursuant to standardized procedures or protocols in primary, community, and free clinics. (AB 1545 Correa) stats 1999 ch 914)

Effective January 1, 2003, B&P Code Section 2836.1 Furnishing is amended to allow NPs to use their furnishing authority in solo practice per Senate Bill 933 (Figueroa) Chapter 764 signed by Governor Gray Davis on September 20, 2002.

Authorized Standardized procedures

Added in legislative session 2003 ch 308 § 34 (SB 819), effective January 1, 2010

2835.**7**. (a) Notwithstanding any other provision of law, in addition to any other practices that meet the general criteria set forth in statute or regulation for inclusion in standardized procedures developed through collaboration among administrators and health professionals, including physicians and surgeons and nurses, pursuant to Section 2725, standardized procedures may be implemented that authorize a nurse practitioner to do any of the following:

(1) Order durable medical equipment, subject to any limitations set forth in the standardized procedures. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) After performance of a physical examination by the nurse practitioner and collaboration with a physician and surgeon, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(3) For individuals receiving home health services or personal care services, after consultation with the treating physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.

(b) Nothing in this section shall be construed to affect the validity of any standardized procedures in effect prior to the enactment of this section or those adopted subsequent to enactment.

Sign for the Request and Receipt of Pharmaceutical Samples and Devices.
Certified furnishing nurse practitioners are authorized to sign for the request and receipt of complimentary samples of dangerous drugs and devices identified in their standardized procedures or protocols that have been approved by the physician. (SB 1558 Figueroa stats 2002 ch 263) to take effect immediately. This new law amends B&P Code Section 4061 of the Pharmacy law to allow CNMs, NPs, and PAs to request and sign for complimentary samples of medication and devices.

Treating STDs
Amended into Section 120582 of the Health and Safety Code effective January 1, 2007:

(a) Not withstanding any other provision of law, a physician and surgeon who diagnoses a sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services, in an individual patient may prescribe, dispense, furnish, or otherwise provide a prescription antibiotic drugs to the patients sexual partner or partners without examination of that patient's partners.
(b) Not withstanding any other provision a nurse practitioner practicing pursuant to BPC Section 2836.1; a certified nurse-midwife practicing pursuant to BPC Section 2746.51; and a physician assistant pursuant to BPC 3502.1 may dispense, furnish, or otherwise provide a prescription antibiotic drug to the sexual partner or partners of a patient with a diagnosed sexually transmitted Chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services without examination of the patient's sexual partners. (AB 2280 Leno stats 2006 ch) (AB 648 Ortiz stats 2001 ch 835)

Workers' Compensation Reports
Section 3209.10 added to the labor code gives nurse practitioners the ability to cosign Doctor's First Report of Occupational Injury or illness for a worker's compensation claim to receive time off from work for a period not to exceed three (3) calendar days if that authority is included in standardized procedure or protocols. The treating physician is required to sign the report and to make a determination of any temporary disability. (AB 2919 Ridley-Thomas stats 2005 extends the operation of this provision indefinitely-AB 1194 Correa stats 2001 ch 229 effective 2001)

Veterans with Disabilities Parking Placards:
Section 5007, 9105, 22511.55 of the Vehicle Code is amended to include nurse practitioners, nurse midwives and physician assistants as authorized health care professionals that can sign the certificate substantiating the applicant's disability for the placard. (AB 2120 Lui stats 2007 ch 116)

Existing law authorizes the Department of Motor Vehicles to issue placards to persons with disabilities and veteran with disabilities and temporary distinguishing placards to temporary disabled persons, to be used for parking purposes. Prior to issuing the parking placard or temporary placard, the Department of Motor Vehicles requires the submission of a certificate, signed by an authorized health care professional providing a full description substantiating the applicant's disability, unless the disability is readily observable and uncontested. Under

existing law, the authorized health care professional that signs the certificate is required to retain information sufficient to substantiate the certificate, and make the information available to certain entities request of the department.

Medical Examination School Bus Drivers
Vehicle Code Section 12517.2 (a) is amended relating to schoolbus drivers driver medical examination to Applicants for an original or renewal certificate to drive a schoolbus, school pupil activity bus, youthbus, general public paratransit vehicle, or farm labor vehicle shall submit a report of medical examination of the applicant given not more than two years prior to the date of the application by a physician licensed to practice medicine , a licensed advanced practice nurse qualified to perform a medical examination, or a licensed physician assistant. The report shall be on a form approved by the department, the Federal Highway Administration, or the Federal Aviation Administration.

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Supervision
Supervision of the NP performing an overlapping medical function is addressed in the standardized procedure and may vary from one procedure to another depending upon the judgment of those developing the standardized procedure. As an example, in one women’s clinic the supervision requirement for performing a cervical biopsy was that a physician must be physically present in the facility, immediately available in case of emergency. For all other

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Supervision of Medical Assistants

~~Nurse Practitioners and Certified Nurse-Midwives may supervise Medical Assistants in "community clinics" or "free clinics" in accord with approved standardized procedures and in accord with those supportive services the Medical Assistant is authorized to perform (Business and Professions Code, Section 2069(a)(1); and Health and Safety Code, Section 1204(a) & (b).~~

Medical Board of California link for medical assistant
http://www.mbc.ca.gov/allied/medical assistant. training.html.
Business and Professions Code 2069 (a) (1) and Health and Safety Code 1240 link is
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SB 111, Chapter 358 (Alpert) was signed by Governor Gray Davis on September 26, 2001 and became effective January 1, 2002. Business & Profession Code Section 2069(a)(1) and Health & Safety Code 1204 a supervising physician and surgeon at a community clinic or free clinic as licensed pursuant to Health and Safety Code 1204 may, at his or her discretion, in consultation with the nurse practitioner, nurse-midwife, or physician assistant provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. The written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, nurse-midwife, or physician assistant and that tasks may be performed when the supervising physician and surgeon are not on site. This delegation to the nurse practitioner or nurse midwife is limited to those licensed clinics under Health and Safety 1240.

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Existing law requires, whenever there is reasonable possibility, as determined by a physician, that a blood transfusion may be necessary as a result of medical procedures, that the physician, by means of a standardized written summary that is published by the Medical Board and now by the Department of Public Health and distributed upon request, inform the patient of the positive and negative aspects of receiving autologous blood and directed and non directed homologous blood from volunteers.

Medi-Cal Billing: Nurse Practitioner Nationally Certified in a Specialty
Section 14132. 41 of the Welfare and Institutions Code is amended services provided by a certified nurse practitioner shall be covered under this chapter to the extent authorized by federal law, and subject to utilization controls. The department shall permit a (nationally) certified nurse practitioner to bill Medi-Cal independently for his or her services. If a certified (nationally) nurse practitioner chooses to bill Medi-Cal independently for his or her service, the department shall make payment directly to the certified (nationally) nurse practitioner. For the purposes of this section, "certified" means nationally board certified in a recognized specialty.

Supervision
Supervision of the NP performing an overlapping medical function is addressed in the standardized procedure and may vary from one procedure to another depending upon the judgment of those developing the standardized procedure. As an example, in one women's clinic the supervision requirement for performing a cervical biopsy was that a physician must be physically present in the facility, immediately available in case of emergency. For all other standardized procedure functions, the supervision requirement was for a clinic physician to be available by phone.

The furnishing or ordering of drugs and devices by nurse practitioners occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time the patient is being examined by the nurse practitioner. For furnishing purposes, the physician may supervise a maximum of no more than four (4) NPs at one time. (BPC 2836.1)

Supervision of Medical Assistants
Nurse Practitioners and Certified Nurse-Midwives may supervise Medical Assistants in "community clinics" or "free clinics" in accord with approved standardized procedures and in accord with those supportive services the Medical Assistant is authorized to perform (Business and Professions Code, Section 2069(a)(1); and Health and Safety Code, Section 1204(a) & (b).

Citation and Fine
NPs, like all registered nurses, are subject to citation and fine for violation of the NPA. Citation and fines are a form of disciplinary action against the RN license and/or certificate. Examples of violations which have resulted in citation and fine are using the title "nurse practitioner" without being certified as a NP by the California BRN and failing to have standardized procedures when performing overlapping medical functions. NPs are encouraged to comply with all sections of the NPA to avoid discipline.

References
B&P Code, Section 2725 RN Scope of Practice, Section 2834 Nurse Practitioner, California Code of Regulation Section 1435 Citations and Fines, Section 1470 Standardized Procedure Guidelines, Section 1480 Standards for Nurse Practitioners.

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For more information, please visit the BRN's Web site at www.rn.ca.gov

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Nurse Practitioners and Certified Nurse Midwives Treating Patients and their Partner or Partners for Sexually Transmitted Diseases

Legislation enacted during the 2005-2006 Session

Effective January 1, 2007, Assemble Bill 2280 (Leno) signed into law by Governor Arnold Schwarzenegger an act that amends Section 120582 of the Health and Safety Code:

(a) Not withstanding any other provision of law, a physician and surgeon who diagnoses a sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services, in an individual patient may prescribe, dispense, furnish, or otherwise provide prescription antibiotic drugs to that patient's sexual partner or partners without examination of that patient's partner or partners. The department may adopt regulations to implement this section.

(b) Not withstanding any other provision of law, a nurse practitioner practicing pursuant to Section 2836.1 of the Business and Professions Code, a certified nurse-midwife pursuant to Section 2746.51 of the Business and Professions Code, and a physician assistant pursuant to Section 3502.1 of the Business and Professions Code may dispense, furnish, or otherwise provide a prescription antibiotic drug to the sexual partner or partners of a patent with a diagnosed sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services, without examination of the patient's sexual partners.

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NURSE PRACTITIONERS AND NURSE MIDWIVES
VEHICLES: PERSONS WITH DISABILITIES: VETERANS WITH DISABILITIES: PARKING PLACARDS

Effective January 1, 2007

Assembly Bill No. 2120 (Lui) Chaptered 116 approved by Governor Arnold Schwarzenegger, July 24, 2006 amend Section 5007, 9105, 22511.55 of the Vehicle Code. The amendments include nurse practitioners, nurse midwives and physician assistants as authorized health care professional that can sign the certificate substantiating the applicant's disability for the placard.

Existing law authorizes the Department of Motor Vehicles to issue distinguishing placards to persons with disabilities and veterans with disabilities and temporary distinguishing placards to temporary disabled persons, to be used for parking purposes. Prior to issuing the parking placard or temporary placard, the Department of Motor Vehicles requires the submission of a certificate, signed by an authorized health care professional, providing a full description substantiating the applicant's disability, unless the disability is readily observable and uncontested. Under existing law, the authorized health care professional that signs the certificate is required to retain information sufficient to substantiate the certificate, and make the information available to certain entities, upon request of the department.

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NURSE PRACTITIONERS COSIGN WORKERS' COMPENSATION CLAIMANT REPORT

Effective January 1, 2005

Section 3209.10 to the Labor Code gives nurse practitioners the ability to cosign Doctor's First Report of Occupational Injury or Illness for a workers' compensation claim to receive time off from work for a period not to exceed three (3) calendar days if that authority is included in standardized procedures or protocols. The treating physician is required to sign the report and to make any determination of any temporary disability. **(AB 2919 (Ridley-Thomas) extends the operation of this provision indefinitely.)**

The Labor Code requires the physician treating a workers' compensation claimant for injuries to submit a report called "Doctor's First Report of Occupational Injury or Illness" to the employer within five (5) working days from the date of the initial examination. (AB 1194, Chapter 229 (Correa), Effective September 1, 2001 included nurse practitioners and physician assistants.)

The new sections of the Labor Code are as follows:

SECTION 1. Section 3209.10 is added to the Labor Code, to read:
3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.
(b) The provision of subdivision (a) that requires the cosignature of the treating physician applies to this section only and it is not the intent of the Legislature that the requirement apply to any other section of law or to any other statute or regulation. Nothing in this section implies that a nurse practitioner or physician assistant is a physician as defined in Section 3209.3.
(c) This section shall remain in effect only until January 1, 2006, and on that date is repealed, unless a later enacted statute that is enacted before January 1, 2006, deletes or extends that date.
SEC. 2. The addition of Section 3209.10 to the Labor Code made by this act does not constitute a change in, but is declaratory of, existing law and neither expands nor limits the scope of practice of nurse practitioners or physician assistants with regard to the delivery of care pursuant to Division 4 of the Labor Code.

SEC. 3. In enacting this act, the Legislature intends to abrogate the opinions expressed by the Administrative Director of the Division of Workers' Compensation as set forth in Minnie Martin v. Los Angeles Unified School District, AD No. 9786-4895, July 6, 1999, to the extent that it precluded a physician assistant from practicing within the scope of the protocol approved by the supervising physician and their lawful scope of practice.

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NURSE PRACTITIONER AND NURSE-MIDWIVES NEW AUTHORITY TO REQUEST AND SIGN FOR PHARMACEUTICAL SAMPLE MEDICATIONS

Effective August 24, 2002

Senate Bill 1558 (Figueroa), Chapter 263, was signed by Governor Gray Davis on August 24, 2002, to take effect immediately. The new law allows certified nurse practitioners and certified nurse-midwives **to sign for the request and receipt of complimentary samples of dangerous drugs and dangerous devices identified in their standardized procedure or protocol that have been approved by the physician**.

BPC Section 4061 Pharmacy law has been updated to: "However, a certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51 (Furnishing), a nurse practitioner who functions pursuant to a standardized procedure or protocol in Section 2836.1 (Furnishing), or protocol, or a physician assistant who functions pursuant to a protocol described in Section 3502.1*, may sign for the request and receipt of complimentary samples of a dangerous drug or dangerous device that has been identified in the standardized procedure, protocol, or practice agreement. Standardized procedure, protocols, and practice agreements shall include specific approval by the physician. A review process, consistent with the requirements of Section 2725 (NPA, Guideline for Standardized Procedure (11)) or 3502.1 (physician assistant) of the complimentary samples requested and received by the NP, CNM, PA shall be defined within the standardized procedure, protocol, or practice agreement.*

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NURSE PRACTITIONERS IN LONG - TERM CARE SETTINGS

Website: http://leginfo.ca.gov/cgi-bin/waisgate?WAISdocID=49961416893+2+0+0&WAISaction=retrieve

Extracted from Welfare and Institutions Code
Division 9
Public Social Services
Part 3
Aid and Medical Assistance
Chapter 7
Basic Health Care
Article 3
Administration

§ 14111. Delegation of duties to nurse practitioners in long-term health care facility.

(a) As permitted by federal law or regulations, for health care services provided in a long-term health care facility that are reimbursed by Medicare, a physician and surgeon may delegate any of the following to a nurse practitioner:

(1) Alternating visits required by federal law and regulations with a physician and surgeon.

(2) Any duties consistent with federal law and regulations within the scope of practice of nurse practitioners, so long as all of the following conditions are met:

(A) A physician and surgeon approves, in writing, the admission of the individual to the facility.

(B) The medical care of each resident is supervised by a physician and surgeon.

(C) A physician and surgeon performs the initial visit and alternate required visits.

(b) This section does not authorize benefits not otherwise authorized by federal law or regulation.

(c) All responsibilities delegated to a nurse practitioner pursuant to this section shall be performed under the supervision of the physician and surgeon and pursuant to a standardized procedure among the physician and surgeon, nurse practitioner, and facility.

(d) No task that is required by federal law or regulation to be performed personally by a physician may be delegated to a nurse practitioner.

(e) Nothing in this section shall be construed as limiting the authority of a long-term health care facility to hire and employ nurse practitioners so long as that employment is consistent with federal law and within the scope of practice of a nurse practitioner.

14111.5.

(a) As permitted by federal law or regulations, for health care services provided in a long-term health care facility that are reimbursed under this chapter, a nurse practitioner may, to the extent consistent with his or her scope of practice, perform any of the following tasks otherwise required of a physician and surgeon:

(1) With respect to visits required by federal law or regulations, making alternating visits, or more frequent visits if the physician and surgeon is not available.

(2) Any duty or task that is consistent with federal and state law or regulation within the scope of practice of nurse practitioners, so long as all of the following conditions are met:

(A) A physician and surgeon approves, in writing, the admission of the individual to the facility.

(B) The medical care of each resident is supervised by a physician and surgeon.
(C) A physician and surgeon performs the initial visit and alternate required visits.
(b) This section does not authorize benefits not otherwise authorized by federal or state law or regulation.
(c) All responsibilities undertaken by a nurse practitioner pursuant to this section shall be performed in collaboration with the physician and surgeon and pursuant to a standardized procedure among the physician and surgeon, nurse practitioner, and facility.
(d) Except as provided in subdivisions (a) to (c), inclusive, any task that is required by federal law or regulation to be performed personally by a physician may be delegated to a nurse practitioner who is not an employee of the long-term health care facility.
(e) Nothing in this section shall be construed as limiting the authority of a long-term health care facility to hire and employ nurse practitioners so long as that employment is consistent with federal law and with the scope of practice of a nurse practitioner.

Citation
Alternate physician visits by NPs-Federal authorization found in the Omnibus Budget Reconciliation Act (OBRA) 1999 and Section 483.40 of the Federal Rules and Regulations (Federal Register, September 28, 1991) State authorization is found in California Welfare and Institutions Code, Section 14111 and 14111.5.

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NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS IN LONG - TERM CARE SETTINGS

Nurse practitioners and clinical nurse specialists, certified by the Board of Registered Nursing, can provide comprehensive medical care to residents in long-term settings according to the standardized procedures co-developed with the physicians with whom they practice. Federal and state laws permit them to **provide alternate visits to residents in long-term care facilities after the physician makes the initial visit**. During these alternate visits they can:

- review the patient's total program of care
- write, sign, and date progress notes
- sign and date orders according to standardized procedures

Nurse practitioners and clinical nurse specialists providing these Medicare and Medi-Cal alternate visits are employed by the physician, clinic, or health plan with whom the standardized procedures are developed. They cannot be employed by the skilled nursing facility to perform alternate visits although they can be employed by or have a contract with skilled nursing facilities to provide other health-illness assessments and implement medical treatment plans per standardized procedures.

Nurse Practitioners (NPs) are registered nurses who have additional education and clinical experience in physical diagnosis, psychosocial assessment, and management of health-illness needs in a variety of practice settings. Nurse practitioners are educated in programs that meet the requirements of the Board of Registered Nursing. Most nurse practitioner programs grant a master's degree to their graduates.

Clinical Nurse Specialists (CNSs) are master's prepared registered nurses who participate in expert clinical practice, education, research, consultation, and clinical leadership.

Whenever NPs and CNSs perform functions or procedures which are considered to be the practice of medicine, i.e., diagnosing disease, prescribing medication, and penetrating or severing tissue, they are required to adhere to standardized procedures.

Standardized procedures are policies and procedures that are developed collaboratively by nursing, medicine, and administration in the organized health care setting where they will be used. This legal mechanism enables the practice of all competently prepared registered nurses to overlap the practice of medicine in California. Physician supervision is not required unless specified in a particular standardized procedure. Unless required under particular standardized procedures a physician's presence is not required when NPs and CNSs are providing their services although physician back up must be available. Physicians are not required by law to co-sign their orders although some third payment sources may require co-signing.

Some of the nursing functions NPs and CNSs commonly perform include obtaining a health history, conducting a physical examination, and ordering laboratory and radiological tests. Some of the medical functions they perform include determining a medical diagnosis, ordering medications, developing a medical treatment plan, and performing medical procedures such as lumber puncture and bone marrow. NPs and CNSs must be identified by name in the standardized procedures.

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Legal Citations

Nurse Practitioners - Business and Professions Code, Article 8, Sections 2834-2837, and California Code of Regulations, Article 8, Sections 1480-1485.

Clinical Nurse Specialists – Business and professions Code Section 2838.2

Standardized Procedures - Business and Professions Code, Chapter 6, Article 2, Section 2725(d), and California Code of Regulations, Article 7, Sections 1470-1474.

Alternate physician visits by NPs and CNSs - Federal authorization found in the Omnibus Budget Reconciliation Act (OBRA) 1990 and Section 483.40 of the Federal Rules and Regulations (Federal Register, September 28, 1991). State authorization is found in California Welfare and Institutions Code, Sections 14111 and 14111.5.